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SELECTING A RESIDENCY FOR COMMUNITY-RESPONSIVE MEDICINE

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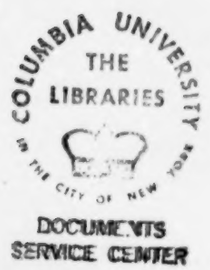

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Services Administration
Bureau of Community Health Services
5600 Fishers Lane
Rockville, Maryland 20857

SELECTING A RESIDENCY FOR COMMUNITY-RESPONSIVE MEDICINE

This booklet was developed for the National Health Service Corps by Project HELP, the education foundation of the Physicians National Housestaff Association. The views expressed in this booklet are drawn largely from a November 1979 conference, coordinated by Martin Kantrowitz, M.D., Chief Medical Officer of the Corps, and attended by a group of present and former Corps physicians and others experienced in community-responsive medicine.

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OVERVIEW

This booklet is designed to help medical students as well as physicians to select residency programs that are oriented to the particular needs of practicing "community-responsive medicine" in medically underserved areas. The booklet is divided into four main parts:

- a description of "community-responsive medicine."
- general guidelines for selecting any residency program.
- specific guidelines for selecting a residency oriented toward "community-responsive medicine."
- a "buyer beware" section on the least useful aspects of residency programs.

The primary audience for this booklet is, of course, those medical students and physicians planning to enter the National Health Service Corps, which employs more than 1,000 physicians in community-designed and community-directed clinics. They provide care in several hundred medically underserved communities. Although Corps physicians practice only in underserved areas, the terms "community-responsive medicine" and "practice in an underserved area" are **not** synomous. "Community responsive medicine" refers to a **style** of medical practice which is critically needed in many underserved areas, but also is suited to other communities and, to some degree, to all medical practices. Therefore, in addition to future Corps physicians, we hope this booklet will prove useful to those who plan to practice "community-responsive medicine" in such settings as:

- private physicians' practices.
- Indian Health Service and Public Health Service sites.
- hospital-sponsored primary care group practices.
- health maintenance organizations.
- community health centers.

"Community-responsive medicine" refers to a medical practice which goes beyond treating the ills of its patients. The community-responsive practitioner tries to determine the causes of a community's health problems . . . and then gets actively involved in trying to solve those problems. The community-responsive practitioner is often the community's unofficial "health leader," fighting to get funds to start a Meals on Wheels program for the elderly or trying to get a local plant to clean up dangerous water pollution.

The Corps wants its physicians to receive strong clinical training in their residency programs. However, in the medically underserved communities where Corps physicians practice, simply being a good doctor is not enough. A Corps physician must have the experience and confidence needed to practice "community-responsive medicine."

This booklet is based on the firsthand experiences of a group of Corps physicians and others who have been involved in "community-responsive medicine" in underserved areas. This group shared their experiences during an all-day conference in November 1979, and their discussions served as the foundation for this booklet. (See page 21 for a complete list of contributors.)

These physicians identified a set of knowledge, skills and abilities that are critical to the practice of "community-responsive medicine." They urged medical students to consider these factors in evaluating prospective residency programs. The five core areas, stressed throughout this booklet, are:

- A broad range of clinical knowledge.
- A sufficient knowledge and experience base so that the physician has the ability and confidence to practice with a high degree of independence.
- A knowledge and appreciation of "non-medical approaches" to improving health status, such as programs involving occupational health and safety, community health promotion, and childhood nutrition.
- Strong skills in interpersonal communications, particularly patient/physician communications and cross-cultural communications.
- Strong skills in community relations and group leadership.

All residency programs are **not** equal in providing the opportunity to develop in these five areas.

This booklet will offer some general guidelines applicable to wise selection of any residency program, and then will offer some specific suggestions for choosing a residency oriented toward "community-responsive medicine." A recurrent theme is to look for a residency program that provides sufficient **flexibility**: flexibility to receive broad clinical experience . . . to participate in suitable electives and preceptorships . . . and to get involved in community health activities.

We hope that this booklet will be read not only by medical students, but also by the directors of residency programs. As the need for community-responsive medicine gains acceptance, residency programs will need to make adaptations in their training regimens to allow for better preparation of those physicians interested in community-responsive practice.

WHAT IS "COMMUNITY-RESPONSIVE MEDICINE"?

"Many residency programs which are excellent in terms of clinical teaching fall far short of preparing a physician to practice 'community-responsive medicine.' "

"In a medically underserved community, simply being a good doctor is not enough."

What is "community-responsive medicine"? Maria Sanchez knows. On a blistering, 102-degree day in July, nine year old Maria cut her foot on a piece of broken glass while she was swimming in an irrigation ditch near her home in Hatch, New Mexico. If Maria lived in Albuquerque or Phoenix, her mother would have rushed her to the closest hospital emergency room. But for the 2,500 residents of the Hatch Valley, a a poor, mostly Chicano farm area, the nearest hospital is a 45-mile drive south down Interstate 25 to Las Cruces. So Maria's mother took her to Dr. Larry Lyons, one of two National Health Service Corps physicians who live and practice in Hatch. They are the "family doctors" to the people of Hatch and some of the "smaller" nearby towns, like Salem and Derry, that sit astride the often dry Rio Grande. Dr. Lyons, a graduate of Jefferson Medical School in Philadelphia, calmed the girl as he stopped the flow of blood, removed three tiny glass slivers, and sewed Maria's foot with nine stitches.

More than 2,500 miles away, in the shadow of Johns Hopkins Medical School, Dr. Bill Parham is seeing patients, too. They bring a variety of complaints: a summer cold that won't leave, a nagging migraine, shortness of breath, an infected rash. Dr. Parham's patients are members of the East Baltimore Medical Plan, a health maintenance organization established by Johns Hopkins to serve the poor and near-poor families of East Baltimore. Dr. Parham, an NHSC physician working with the Plan's medical staff, will rarely see a badly bleeding patient like Maria Sanchez, since the Hopkins ER is only a few blocks away. But like Hatch's Larry Lyons, he and more than 1,000 other Corps physicians are practicing "community-responsive medicine" in a medically-underserved area.

To the present and former Corps physicians who contributed to this booklet, the term "community-responsive medicine" carries a variety of meanings. First, a community-responsive medical practice treats a

wide range of patient problems: from routine fevers, aches, and pains to potentially life-threatening chest and abdominal pains, difficulty in breathing, and other serious symptoms. While some community-responsive practitioners (like Bill Parham of Baltimore) are located near specialty back-up services, many (like Larry Lyons of rural Hatch) are not. The community-responsive practitioner needs strong clinical knowledge in a variety of fields in order to have the capability and confidence to practice with a high degree of independence.

However, in a medically underserved community, simply being a good doctor isn't enough. A community-responsive physician goes beyond treating patients' ills . . . and begins to look for the causes of a community's major health problems. The physician gets involved in looking for solutions, and, in many communities, becomes the unofficial "health leader."

In Hatch, Dr. Lyons worked with community leaders to secure a half-million dollar federal loan to build a new clinic and dental center. In an Appalachian town in Central Pennsylvania, 35 miles from the nearest hospital, Dr. Ken Veit and his fellow Corps providers helped train the volunteer ambulance crews in emergency medical techniques. "The people were responsive and enthusiastic that doctors would come in and teach them how to take a pulse and how to read a blood pressure," said Veit. "It really communicated to the community that we cared about them and were willing to do something about it."

These kinds of activities, our contributing physicians felt, called for skills in interpersonal relations, group leadership, and community relations, as well as some experience in such community health fields as occupational health and health promotion. All residency programs are not equal in providing opportunities to build these skills, they said.

A Definition of "Community-Responsive Medicine"

A more formal definition of "community-responsive medicine" comes from Donald Madison, M.D., whose Rural Practice Project at the University of North Carolina at Chapel Hill trains health practitioners for underserved areas. Writing in the January-February issue of **Public Health Reports**, Madison said:

One Physician on Community-Responsive Practice

Writing in the May 9, 1980 issue of JAMA, Fitzhugh Mullan, M.D., director of the National Health Service Corps, recounted his experience as a Corps physician:[1]

"Speaking personally, there were many rewards and joys to working as a community practitioner. We provided first-rate, personal care to patients who would not have received it otherwise. We helped train numbers of community residents as clinic staff members and saw them go on to successful health careers. We were warmly received in the Chicano community and learned much about cross-cultural life among some of America's oldest inhabitants. Our patients often shared farm products or in-kind gifts with us. One board member made it her job to bring fresh fruits and vegetables to the clinic for the staff every afternoon.

"As the same time, we encountered many difficulties that are not part of the traditional practice experience. While certain of the physicians in town were extremely supportive of our efforts and generous in their consultations, others tended to be contemptuous of us. An internist told me in the hospital one day, 'I was all against you when you came but now I see a real role for you. You have relieved me of a dozen deadbeat patients. I am happy that you're saving me all that time and money.' "

Mullan recalled many aspects of community practice in which he felt uncomfortable and ill-prepared by his training. Later, as director of the NHSC, he learned that his experiences were shared by hundreds of other Corps physicians. Medical school and residency training had not prepared them to deal with "community sensitivities" on a variety of issues. There was the question of "to coat or not to coat," that is, whether the practitioner's dress style should be formal or should match the community's. There was the "privacy problem," particularly in small towns, where patients wanted only the physician, not the clinic staff, to see their medical record; they feared that the clinic staff would gossip about their problems. An even more serious issue was "the salary gap," the resentment produced as the physician earned "twice as much as the clinic administrator, three times as much as the lab technician, or six times as much as the outreach worker." A predictable problem was the clash between the physician and community leaders over, "Who's in Charge Here Anyway?" And finally, there was the "Cake Bake Syndrome," in which the physician felt obligated to participate in community fund-raising, but questioned the utility of spending Saturday afternoons "hawking Christmas cards" or organizing dances, when "the total proceeds will pay for one or perhaps two days of hospital care for one person."

Individual physicians, of course, found ways to cope with each of these problems. For example, some physicians found that "salary-sharing, no matter how small," helped neutralize the "salary gap" and solidify the physician as a member of the "team." However, on-the-job ingenuity is no substitute for the physician obtaining as much preparation as possible, mainly in a residency, in the special aspects of community-responsive practice.

[Community-responsive practitioners] "must be conscious of 'community,' accepting the notion that their patients come from some larger denominator of people. Whether the community is defined as a county, a town, a neighborhood, all migrant farm worker families within a prescribed area, a group of people sharing the same health problems, or simply the collectivity of the practice's clients, the practitioners must be able to conceive of the health of that community of persons as their responsibility to some degree. Second, they must be able to conceive of programs to meet the health needs of their community that may involve the practice in activities that go beyond one-to-one medical care. And thirdly, the practitioners must be able to exercise health leadership, both within and from their practices."[2]

What relationship does this definition have to selecting a residency, in preparation for Corps service specifically, or for community-responsive practice in general?

Corps physicians are well-prepared to practice medicine. Most have completed residencies in internal medicine, family practice, or pediatrics, and are board-certified or board-eligible. But despite this strong medical training, many Corps physicians seasoned by field experience report that "something was lacking" in their formal preparation to practice medicine in medically underserved communities.

"Many residency programs which are excellent in terms of clinical teaching fall far short of preparing a physician to practice community-responsive medicine," explained Dr. Martin Kantrowitz, the Corps Chief Medical Officer."

The next section of this booklet will offer some guidelines applicable to judicious selection of any residency program. This discussion will lay a foundation for a more detailed set of guidelines for choosing a residency which offers strong preparation for community-responsive practice.

SELECTING A RESIDENCY PROGRAM: SOME GENERAL GUIDELINES

"The interview is probably the most important step in choosing a program . . . Heed your 'gut' reactions (to) the people, to the facilities and to the program as a whole."

Dan Williams, M.D., and
J. Patrick Tokarz, M.D.,
in **The New Physician**[3]

In general, the purposes of a residency are to provide the physician:

- the opportunity to be exposed to more patients than in medical school, with an emphasis on the kind of patients likely to be encountered in later practice.
- gradually increasing responsibility for patient care, coupled with sufficient supervision and consultative services to assure not only high quality education, but also high quality patient care.
- the opportunity to be exposed to varying techniques of patient management, along with an opportunity to carefully evaluate the different diagnostic, preventive, treatment, and rehabilitation modes through observation as well as research.

Before examining what to look for in terms of preparation for community-responsive medicine, medical students should be grounded in some general guidelines of sound selection technique. There are abundant resources on residency selection, including:

- **AMSA's Student Guide to the Appraisal and Selection of House Staff Training Programs**, American Medical Student Association, 2nd Edition, edited by Martin J. Raff, M.D., Phil P. Aaron, M.D. and C. Elliott Ray, M.D.; available from AMSA, Box 131, 14650 Lee Road, Chantilly, VA 22021.
- **Guide to Family Practice Residency Programs**, American Academy of Family Physicians, and American Medical Student Association, 1979.
- **The New Physician**, August 1978, "Selecting a Residency," pp. 27-39.

- **Directory of Residency Training Programs Accredited by the Liaison Committee on Graduate Medical Education**, published annually by the American Medical Association.

These and other resources are generally available in medical school libraries.

Four Step Process

Most students follow a four step process in choosing a residency. For some goal-oriented students, this process is indeed taken step-by-step, while for others it is more or less intuitive. In either event, the student's basic steps are to:

1. **Make preliminary decisions relevant to:**
   - geographic location.
   - specialization(s).
   - type of ultimate practice: e.g., private practice, research, institutional practice, full-time clinical teaching, combination or other.

2. **Select residency programs to visit, based upon:**
   - word-of-mouth information from residents and other students.
   - catalogs from residency programs.
   - advice from faculty.

   NOTE: The AMSA Booklet cautions: "Students are frequently dissatisfied with faculty efforts in advising and assisting them in the selection of training programs . . . individual faculty members often know too little about other house staff programs . . . often do not know enough about the students . . . and (may believe) it makes little difference where a doctor receives post-doctoral education so long as it is in a university-affiliated hospital . . .[4] This warning suggests that students should not permit faculty advice to substitute for a thorough, personal review of available residency opportunities.

3. **Visit and interview at a selected number of programs, including interviews with:**
   - faculty.
   - attendings.
   - residents from several years.

   NOTE: Williams and Tokarz, writing in **The New Physician**, suggest: **"Many students have found it useful to participate in several trial interviews at institutions close to their school so they will feel more at ease when they interview at their top choices.**[5]

4. **Make a careful evaluation of which program to rank highest in the matching program, based upon:**
   - the interview
   - written materials, including the schedule of rotations and a sample on-call schedule
   - discussions with medical school faculty and other students.

In the course of this process, the student seeks to compare the various residency programs against the student's personal criteria for a prospective training program. At the same time, the student is trying to make a good impression in order to be ranked high by the program when matching comes around. The AMSA booklet provides some guidelines for making a good impression and still asking tough questions about an institution's program.

The Interview

Evaluating a residency during a brief visit is difficult. It is impossible to ask all the essential questions in the time allotted, and to sort out what may be conflicting answers. The questions below are offered not as a laundry list, but to suggest a range of possible areas for questioning. Remember: Talk to current residents . . . get "gut" reactions . . . don't rely just on faculty answers . . . be critical.

Questions to Ask When Considering a Residency

1. How much responsibility do residents have for patients, particularly in the second and third years?
2. What is the relationship between attending physicians and house officers?
   - who is responsible for ordering tests and medications?
   - who can discharge patients?
   - who has ultimate responsibility for patients?
   - how much time do attendings devote to teaching?
3. How many house officers are there?
   - is that number sufficient for educational purposes or is the hospital just after "cheap labor"?

4. When the house officer is on call:
   - how many patients is he/she responsible for? is this realistic?
   - who is available for consultation? (Is it a senior resident, or an attending who may dislike being disturbed at home?)
   - how is information communicated at shift change?
5. What is the rotation schedule, particularly with regard to:
   - required rotations: where and when? types of hospitals?
   - elective rotations: how much opportunity?
   - emergency rotations: does ER treat mostly "true emergencies" or mostly primary care problems? status of the ER in the hospital? supervision by certified emergency physicians? reputation of the ER in the community?
6. What is the patient load like in terms of:
   - service vs. private patients?
   - patients' age mix?
   - types of illnesses and severity of illnesses?
   - specialty care . . . will the resident be exposed to an ICU, CCU, burn care unit, neonatal unit, delivery room, alcohol and substance abuse unit, and other specialty units?
7. Is the workload reasonable, with regard to:
   - on call schedules?
   - paperwork? (e.g., is a dictation machine available?)
   - "scutwork"? (e.g., IV's, orderly duties)
   - flexibility of scheduling?
8. How do the faculty and residents rate the "quality" of the hospital's:
   - nusing staff?
   - radiology, pathology, and other ancillary services?
   - medical records?
   - library?
9. What about the terms and conditions of work, including:
   - salary and benefits?
   - house staff association?
   - provision of meals and uniforms?
   - availability of housing?
   - on call rooms?
10. What about family considerations, such as:
    - employment opportunities for a spouse?
    - housing?
    - availability of child care?

These general areas of questioning relate to most medical students. Those bent on pursuing community-responsive medicine should add to this list the areas discussed in the next section.

SELECTING A RESIDENCY PROGRAM FOR COMMUNITY-RESPONSIVE MEDICINE

"Most internships and residencies keep people in the same track as medical school . . . community medicine requires a residency that widens the person's perspective, as well as their clinical skills."

Barbara Spivak, M.D.
Corps physician in
Watertown, Mass.

The term "community-responsive medicine" is not easy to define. It is not a clear-cut field such as internal medicine or ophthalmology. Community-responsive medicine embodies many of the medical concepts that characterize family practice, but not all family practice residencies prepare physicians well for community-responsive practice. There are no boards in community-responsive medicine, and no professional society represents its interests.

And yet, those physicians who have practiced in underserved community settings know that community-responsive medicine is a specialty in itself. Moreover, like pediatrics or surgery, it is possible to identify a **basic or core set of knowledge, skills, and abilities which are intrinsic to community-responsive medicine**.

On page 13 are listed five core areas of community-responsive medicine. Accompanying each area is a brief description of its implication for selecting a residency program.

Five Core Areas of Community-Responsive Medicine	Implications for Selecting a Residency
• A broad range of clinical knowledge, including the ability to recognize and treat or stabilize life-threatening conditions as well as the scope of primary care problems.	• The residency should provide sufficient opportunities and flexibility for gaining experiences outside the primary specialty.
• A sufficient knowledge and experience base so that physician has the ability and confidence to practice with a high degree of independence.	• The residency should provide sufficient experience in relatively independent practice settings, such as primary care practices, continuity clinics, emergency room and satellite clinics.
• Skills in interpersonal communications, particularly in communicating with and understanding patients and families from cultures different from the practitioner's.	• The residency should offer experiences and role models in good physician/patient communications as well as broad cultural exposure.
• Experience in "non-medical" health programs.	• The residency should offer opportunities to learn about such community health fields as occupational health and safety, health promotion, and disease prevention.
• Skills in community relations and group leadership.	• The residency should provide opportunities and flexibility to get involved in community activities, particularly those which are health-related.

Avenues of Questioning for Selecting a Residency Program for Community-Responsive Medicine

To determine what to look for in selecting a residency in preparation for community-responsive medicine, we asked the group of Corps physicians mentioned earlier what they would look for in a residency program, given 20/20 hindsight. We supplemented their views with observations from residency program directors and others involved in the field.

What follows is a list of suggested questions which "those who've been there" feel are critical elements to consider in evaluating a residency program. **It is not anticipated nor realistic to expect that a residency seeker will ask all these questions. Our intent is to suggest some possible avenues of inquiry that often are glossed over in the interview.**

Does the Program Provide a Broad Range of Clinical Knowledge and Skills?

- Is the program respected or known for its clinical strengths? Do the faculty practice what they teach?
- In either required or elective rotations, how much experience will the resident recieve in:
  - emergency treatment of a variety of life-threatening conditions?
  - diagnosis and treatment of conditions which might be treated in the ER or inpatient services in an urban hospital, but which the community physician often must recognize and treat in the office?
  - settings which are removed from the hospital, so that the resident must practice independently (to some extent) of specialty back-up services?
- How much opportunity will the resident have to work with "non-physician" professionals, such as social workers, nutritionists, and psychologists?
- How much actual experience will the resident have delivering care outside the primary specialty? For example, in addition to required rotations, the Corps feels:

  Residents in pediatrics should have approximately six months training in:
  - emergency medicine
  - inpatient adult medicine

- outpatient adult medicine
- outpatient OB/GYN, family planning, and pre-natal care
- outpatient and emergency orthopedics
- behavioral psychiatry.

Residents in internal medicine should have about six months training in:
- outpatient pediatrics
- outpatient OB/GYN, family planning, and pre-natal care
- outpatient and emergency orthopedics
- behavioral psychiatry.

Residents in OB/GYN should have about six months training in:
- emergency medicine
- inpatient adult medicine
- outpatient adult medicine
- outpatient pediatrics, including newborn care
- outpatient and emergency orthopedics
- behavioral pscyhiatry.

Residents in psychiatry should have about six months training in:
- emergency adult and pediatric medicine
- outpatient OB/GYN
- outpatient adult medicine
- outpatient pediatrics.

Residents in family practice, whose required rotations include emergency medicine, pediatrics, OB/GYN and other specialty areas, should assure that at least several months of training:
- are spent in community-based electives and preceptorships.
- are spent working with specialized populations likely to be encountered in a community-responsive practice. Such experiences might include working in a nursing home, juvenile detention center or drug abuse clinic.

Does the Program Provide Residents the Opportunity to Build Confidence in their Ability to Practice Independently?

- In required rotations, how much independent responsibility do residents have?
  - Who is responsible for the residents?
  - How closely do they supervise residents?
- What is the degree of continuity of care for patients the resident will see in outpatient settings? Specifically, are there rotations in:
  - family practice clinics?
  - continuity clinics?
  - prepaid health plans (e.g., HMOs)?

- How much opportunity will residents have for elective rotations and preceptorships in such settings as:
  - National Health Service Corps sites?
  - Indian Health Service sites?
  - neighborhood and community clinics?
  - continuity clinics?
  - private group practices?
  - satellite clinics?
  - HMOs?

Does the Program Provide an Opportunity to Learn and Build Skills in Community Relations and Group Leadership?

- How much opportunity will residents have to become active in such pursuits as:
  - community activities?
  - hospital committees and task forces?
  - housestaff association?
- Through required or elective rotations, or through community involvement, to what extent will a resident experience some of the characteristics found in many medically underserved communities, such as:
  - language barriers?
  - cultural barriers?
  - poor public transportation?
  - anti-medical attitudes?
  - absence of a "peer group" with which the physician may be familiar?
  - unfamiliar environment not only for the physician, but also for both the working and non-working spouse and family?
- How active is the hospital in the community? Does the hospital see part of its mission as assuming leadership in addressing community health problems? Indicators of such a mission might be:
  - community or satellite clinics
  - community representation on hospital committees
  - special programs in maternal and child care, adolescent pregnancy, alcoholism and substance abuse, and so on.

Does the Program Offer Opportunities to Build Skills in Interpersonal Communications?

- Does the program put a premium on, or give "lip service" to, good patient/physician communications?
  - Are there educational opportunities in areas of human behavior, such as family dynamics, interviewing skills, psychological illness, and death and dying? Who teaches these programs and what are their qualifications?

- Are there courses or grand rounds in patient/physician communications?
- How often are patient care conferences held? Who attends?
- Is there sufficient time for taking histories?
- Does the hospital have an effective patient education program?
- Can you observe any "role models" of good patient/physician communications?

Does the Program Include not only Exposure to Clinical Services, but also to such "Non-Medical" Programs as:

- health promotion, including patient education, health screening, and community health education
- occupational health and safety
- childhood immunization
- disease prevention
- alcoholism and substance abuse
- adolescent pregnancy

NOTE: Many of the foregoing questions ask about "opportunities." The term "opportunity" really has two aspects. One is "time" . . . will the resident have enough flexible time to become involved in community activities, medical staff affairs, or the housestaff association, or do residents find virtually all their time is occupied by required rotations? The second aspect is availability . . . Are there community projects for which interested residents can volunteer? Does the medical staff give residents a real role on its committees, or just token representation? One way to measure "opportunity" is to ask to what extent present and past residents have participated in these activities.

CAVEAT EMPTOR (BUYER BEWARE)

"Most people pick a residency like they buy a new car. They've half made up their mind already, and they avoid asking the very questions that might interfere with their decision. They'd be better off picking a residency like a used car, which not only means asking the previous owners (residents) about their experiences . . . it also means "caveat emptor."

An Anonymous
Fourth Year
Resident

To balance the list of attributes in the previous section, we asked our contributing physicians to list the "least useful elements" of residency programs, in terms of preparation for community-responsive medicine. Any such discussion is, of course, subjective. Moreover, many of the suggestions apply equally to all residency programs, not only those oriented toward community-responsive medicine.

Least Useful Attributes of a Residency

- **Lack of a core curriculum** that makes clear exactly what clinical knowledge and skills a resident can expect to learn.
- **Excessive on-call schedule**, particularly since such a schedule would not allow time for independent study, following patients in continuity clinics, community involvement, and other "non-required" activities.
- **Excessive high-powered intellectual harassment** from attending physicians, faculty, senior residents, and residents in other specialties. (This issue was cited with particular reference to family practice residents. For example, do other residents "respect" the fact that FP's are getting a core knowledge of all fields, or is there a lack of respect for the FP's failure to know a given specialty in depth? Are FP's permitted to gain "hands on" experience in the procedures they will need to perform in practice?)
- **Lack of an effective housestaff organization**. "Nothing can turn a good training experience into a headache faster than a group of underpaid, overworked, unrepresented and generally disgruntled house officers. (Ask) is there a housestaff organization and does

it function effectively to insure rights and improve patient care?" (from Williams and Tokarz in **The New Physician**)[6]

- **Fragmentation and a lack of continuity of care** . . . amongst the ER, outpatient departments, and inpatient services.
- **Excessive scutwork** . . . the perennial controversy over who should put in IV's epitomizes this overworked but nevertheless critical issue.
- **Antagonistic or overly cynical attitudes** toward innovative programs such as health promotion, natural childbirth, birthing centers, ambulatory surgery, hospice care, quality assurance, physician extenders, occupational health and safety, health maintenance organizations, and National Health Service Corps itself.

SUMMING UP...

"The very first thing to look for is strong clinical training."[7]

Don Madison, M.D.

Community-responsive medicine requires preparation which residency programs provide in widely varying degrees. In this booklet, we have sought to offer some guidelines to those medical students and physicians seeking such preparation. The physicians we consulted emphasized looking for a residency program that provides:

- strong clinical preparation
- opportunities to build skills for independent practice
- exposure to community relations and group leadership
- opportunities to build patient communications skills
- expansion of knowledge and awareness of "non-medical" means of improving a community's health.

The single most important characteristic of a residency program must be strong clinical training. However, in community-responsive medicine, being a good clinical doctor is not enough. A residency program should go further. It must allow the resident sufficient flexibility and encouragement to gain experience in the critical skill areas of community-responsive medicine.

CONTRIBUTORS

This booklet was prepared by Barry S. Bader for Project HELP, which expresses its appreciation to those who contributed to the final product. Of particular importance are the physicians and non-physicians who met in November of 1979 and willingly shared their experiences about community-responsive practice. They are:

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Martin Kantrowitz, M.D., Chief Medical Officer of the Corps, who practiced and taught emergency and family medicine in New Mexcio.

Larry Lyons, M.D., a Corps physician in rural Hatch, New Mexico.

Donald Madison, M.D., director of the Rural Practice Project at the University of North Carolina at Chapel Hill.

Carron Maxwell, a program planner at Chicago's Northwestern Memorial Hospital.

William Parham, M.D., a Corps physician at the East Baltimore Medical Plan.

Alan Ramsey, M.D., a Corps physician in Alamosa, Colorado.

Barbara Spivak, M.D., a Corps physician in Watertown, Massachusetts.

Kenneth Veit, D.O., a regional official for the Corps in Philadelphia and a former Corps practitioner in rural Pennsylvania.

Thanks also go Rae Loen and Deborah Parham of the Corps headquarters staff, and Marcia Muir, a medical student at George Washington University.

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